American Hospital Association

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Responses from the American Hospital Association

"Keeping the Promise: Site-of-Service Medicare Payment Reforms"

May 21, 2014

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association's (AHA) appreciates the opportunity to provide additional feedback on the hospital perspective on site-of-service payment proposals. Please find below our answers to specific questions posed by Subcommittee Members.

THE HONORABLE JOSEPH R. PITTS

1. The AHA agrees that Medicare insolvency would jeopardize care for millions of seniors who depend on the program. The longer Congress waits to address Medicare insolvency, the more difficult it will become to address the situation. We urge the Congress to address this issue sooner rather than later. To this point, the AHA has published and disseminated a list of "Deficit Reduction Alternatives in Health Care."

2. The AHA agrees that cost savings to Medicare beneficiaries under a combination of the Part A and B benefits with a catastrophic cap, as recommended by the Medicare Payment Advisory Commission (MedPAC) and the President's Fiscal Commission, should be considered as an alternative to further cutting provider payments, which could in turn impede beneficiary access. For this reason, we included this in the list of deficit reduction alternatives referenced above.

THE HONORABLE MIKE ROGERS

1. The AHA does not track those numbers. In terms of valuation, spending and acquisition, U.S. Oncology was acquired by McKesson for $2.16 billion in 2010. At the time, U.S. Oncology distributed $2.4 billion in oncology pharmaceuticals annually (Medicare pays an additional 6 percent above the Average Sales Price for drugs administered by U.S. Oncology). Under your legislation, the Moran Company estimates the $2.9 billion you would cut hospital cancer care for patients over 10 years would all go to free-standing cancer sites.

In fact, hospital outpatient departments (HOPDs), as you know, have much more comprehensive licensing, accreditation and regulatory requirements than free-standing physician offices. This includes hospital licensure requirements in all states, Medicare conditions of participation, and additional oversight and regulation by a large number of other government agencies such as the Food and Drug Administration, Environmental Protection Agency and Occupational Safety and Health Administration, to name a few. These same standards are not required of physician offices, but must be complied with when billing Medicare as an HOPD.

2. Physicians refer sicker and more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients with a higher average risk for complications. An AHA analysis of Medicare data demonstrates that patient severity is nearly 24 percent higher in HOPDs than in physician offices.

   But the fact is, patients often cannot find care at free-standing cancer sites. Hospital-based clinics provide services that are not otherwise available in the community to vulnerable patient populations. Your proposed reduction in outpatient Medicare revenue to hospitals would threaten access to critical hospital-based services, such as care for low-income patients and services for patients with multiple conditions. HOPDs serve a higher percentage of dual-eligible patients (28 vs. 19 percent) than physician offices. HOPDs also serve a higher percentage of disabled patients (23 vs. 15 percent) and non-white patients (20 vs. 14 percent).

3. Payment should reflect HOPD costs, not physician payments. HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule (PFS) (and, specifically, the practice expense component) is based on responses to physician survey data held flat for years due to the cost of various physician payment "fixes." Physicians widely agree that the Medicare PFS underpays for their services, but as you will recall from MedPAC's testimony at the hearing, their site-neutral payment proposals all reduce payment to those PFS levels.

   Furthermore, capping these payments would lead to distortion of the hospital outpatient payment system and the outpatient ambulatory payment classification (APC) relative weights due to the artificial payment caps that are no longer related to hospital costs. Each APC has a relative weight based on the geometric mean cost for the procedures in the group relative to the geometric mean cost for a mid-level clinic visit.

4. Hospitals have greater costs than physicians providing the same service in their offices. HOPDs must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements than do free-standing physician offices. CMS acknowledged this in its July 19 proposed rule for the 2014 physician payment system:

   > *When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional*

> *combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively.*

Unpaid "stand-by capacity" costs – such as around-the-clock availability of emergency services; cross-subsidization of uncompensated care, EMTALA and Medicaid; emergency back-up for other settings of care; disaster preparedness; a wide range of staff and equipment – make hospital-level care more expensive, and these costs are spread across all hospital services, including outpatient E/M services.

5. Hospitals already lose money treating Medicare patients in HOPDs. According to MedPAC's March 2014 report, Medicare margins were *negative* 11.2 percent for outpatient services in 2012. Additional cuts to HOPD payments threaten beneficiary access to these services. CMS acknowledged this in its July 19 proposed rule for the 2014 physician payment system:

> *When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively.*

Cutting care for cancer patients, when HOPDs are already underpaid by 11.2 percent, would jeopardize seniors' ability to find cancer care at a time they are most vulnerable, which is why the AHA opposes this proposal.

6. The 340B Drug Pricing Program was established to help safety-net health care providers stretch scarce resources, enabling improved patient access to pharmaceuticals and allowing more hospitals to provide comprehensive services. The need for such a program became apparent after the establishment of the Medicaid rebate program in 1990. Pharmaceutical companies stopped providing discounts on drugs sold to non-Medicaid providers, which resulted in higher drug costs for many safety-net health facilities caring for the nation's most vulnerable patient population. As a result of this market change, Congress, with broad bipartisan support, enacted the 340B Drug Pricing Program to provide safety-net health care facilities relief from high prescription drug costs. Since the program's inception, Congress expanded the program to additional safety-net hospitals, thereby enabling improved health care access to more low income and uninsured patients.

   There are variety of ways hospitals use the program to benefit the patients and communities they serve. The notion that 340B is a main driver of consolidation in the oncology field is misguided. Larger market forces have influenced independent oncology practices to merge with their community hospitals. Hospitals are strengthening ties to each other and physicians in an effort to respond to new global and fixed payment systems, as well as incentives for improved quality and efficiency, implementation of electronic medical records, and care that is more coordinated across the continuum.

   Hospitals and their outpatient departments receive higher payment rates due to their additional capabilities and requirements. Hospitals care for all patients who seek emergency care, regardless of their insurance status or ability to pay; maintain standby disaster readiness capacity in the event of a catastrophic occurrence; and treat patients who are sicker and require more complex services than those treated by private practice oncology clinics.

   Hospitals face many challenges to maintain the full panoply of services that the public expects to receive when they are sick and need care 24/7 – challenges that are not confronted by private practice oncology clinics. Increased demand for specialized services, staffing shortages, diminishing financial support from Medicare and Medicaid, capital expenses, increased accreditation requirements, and greater expectations for emergency preparedness are just a few of the challenges hospitals face. Given all of these additional requirements, the cost of providing care in a hospital outpatient oncology department is far greater than that of a private practice oncology clinic. It is important to note that 340B discount prices help eligible hospitals meet the needs of their patients regardless of their insurance status. Hospitals' ability to use 340B to stretch their scarce resources is vital given the additional requirements placed on hospitals.

THE HONORABLE GENE GREEN

1. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in the Medicaid drug rebate program to sell outpatient drugs at discounted

prices to taxpayer-supported health care facilities that care for uninsured and low-income people. The 340B program enables eligible entities, including hospitals and community health centers, to stretch scarce federal resources to reduce the price of pharmaceuticals for patients, expand services offered to patients and provide services to more patients. In addition, the program generates savings for both the federal and state governments.

The program allows these hospitals to further stretch their limited resources and provide additional benefits and services to their communities. For example, Regional One Health uses the savings realized from its participation in the 340B program to expand pharmaceutical access to uninsured patients. The 340B program helps to offset the health system's costs of providing free medications to patients. In addition, the savings from the 340B program are used for a home-based IV program for vulnerable patients, provide operational support for medication assistance programs, and support pharmacy operations in the outpatient HIV clinic.

If the 340B program did not exist or was sharply scaled back, many of the hospitals that currently benefit from the program would lose their ability to provide enhanced care to their patients and the communities they serve. Many of the services supported by the 340B program at hospitals like Regional One Health could be put in jeopardy if drastic changes were implemented in the 340B program. As a result, patient care would suffer.